CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPL	
		155357	B. WIN			03/07/2	011
NAME OF I	PROVIDER OR SUPPLIER	,		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	NO VIDER OR SUPPLIER				I WALKER DRIVE		
		& LIVING COMMUNITY, LLC		PENDL	ETON, IN46064		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFFING INFORMATION)	+	IAU	·		DATE
F0000	This visit was for	r the Recertification and	F00	00	Preparation and/or execution of		
	State Licensure s	survey.			this plan of correction in gener or this corrective action in	aı,	
					particular, does not constitute	an	
	Survey dates: M	Iarch 1, 2, 3, 4, and 7,			admission or agreement by the		
	2011				facility of the facts alleged or		
					conclusions set forth in this statement of deficiencies. The	<u>,</u>	
	Facility number:				plan of correction and specific		
	Provider number				corrective actions are prepare		
	AIM number: 10	00291470			and/or executed in compliance	;	
					with state and federal laws.		
	Survey team:				This plan of correction constitu	ıtes	
	Tammy Alley RN				our credible allegation of		
	Donna M. Smith				compliance with all regulatory		
	Toni Maley BSW				requirements. Our date of compliance is: April 6, 2011.		
	Karen Lewis RN	(March 3, 2011)			7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7		
					_		
	Census bed type:	:					
	SNF/NF: 93						
	Residential: 46						
	Total: 139						
	Census payor typ	pe:					
	Medicare: 20						
	Medicaid: 44						
	Other: 75						
	Total: 139						
	Sample: 10						
	Sample: 19 Residential: 7						
		umpla: 10					
	Supplemental Sa	unpie. 19					
	These deficienci	es also reflect state					
		dance with 410 IAC 16.2.					
	iniumgs in accor	uance with 410 IAC 10.2.					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

(X6) DATE

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Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B9NP11 Facility ID: 000248 If continuation sheet

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155357	B. WIN			03/07/2	011
			D. (12.)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				WALKER DRIVE		
	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	Quality review concentration Cathy Emswiller	ompleted 3-10-11 RN					
F0160	Based on record	review and interview, the	F01	60	<u>F 160</u> I. Resident # 104,		04/06/2011
SS=B	facility failed to	ensure resident funds			Resident #105, Resident #100		
00 B	were dispersed w	within 30 days of resident			Resident #107, Resident # 108 Resident #109, Resident #110		
	discharge from th	ne facility for 10 of 10			Resident #112 and Resident #		
	discharged reside	ents reviewed for account			accounts were closed 3/21/1	<u>1</u> II.	
	dispersion in a su	applemental sample of			After review, all discharged		
	•	s 104, 105, 106, 107, 108,			residents in the last 30 days w		
	109, 110, 111, 11				reviewed for dispersement of funds and no issues were		
	, , ,	, /			identified, other than the reside	ents	
	Findings Include				identified in the survey. III. The		
	i mamgs merade	•			systemic change is that the		
	1 Δn undated n	olicy titled "Resident			facility policy has been amend		
	_	as provided by the			to include monthly report for a discharges. The Business Offi		
	_	1 3/7/11 at 10 a.m., and			manager received education	00	
		nt. The policy indicated:			regarding these systemic		
		n Account: In case of			changes. Resident funds will b		
	_	ge, a final accounting of a			reviewed on a monthly basis in addition to quarterly review. IV		
	-	al funds is completed			100% of discharges will be		
	*	nt of any outstanding			reviewed by the Business Office	ce	
					Manager and a report will be		
		facility. The balance			submitted to the Administrator		
	_	e conveyed within 30			findings, 5 times per week for days, then 5 times per month t		
	days to the indiv	•			150 days, then 3 times per mo		
		inistering the resident's			for 180 days to total 12 month	s.	
	estate"				Results of report findings will be	oe	
	3/7/11 at 9 a.m. residents had out	s were reviewed on The following discharged estanding balances in the ccount greater than 30			reported to the QA committee monthly for 12 months, to assi with additional recommendation if necessary. COMPLETION DATE: April 6, 2011.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155357		LDING		03/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DETCIENCT)		DATE
	days after dischar	rge from the facility.					
	Resident # 104: a balance of \$480 Resident # 105: with a balance of Resident # 106: with a balance of Resident # 107: with a balance of Resident # 108: with a balance of Resident # 109: with a balance of Resident # 110: with a balance of Resident # 111: with a balance of Resident # 111: with a balance of Resident # 112: with a balance of Resident # 113: with a balance of Resident # 113: with a balance of Resident # 113: with a balance of \$00 Resident # 113: with \$00 Residen	discharged on 1/911 with 0.31 discharged on 3/26/10 \$\frac{5}{2}.20\$ discharged on 12/18/10 \$\frac{5}{2}20.00\$ discharged on 1/26/11 \$\frac{5}{2}26.65\$ discharged on 12/5/10 \$\frac{5}{2}50.09\$ discharged on 3/27/09 \$\frac{5}{2}.02\$ discharged on 3/15/10 \$\frac{5}{2}.02\$ discharged on 8/22/10 \$\frac{5}{2}\$.03 discharged on 12/22/10 \$\frac{5}{2}\$50.01 discharged on 1/7/11 \$\frac{5}{2}\$100.03					
		ent accounts. She I not been trained on the					
		ount. She indicated there					
	was a corporate of	consultant who was					
	_	ident funds accounts.					
	On 3/7/11 at 10 a	.m., during interview,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155357	B. WIN			03/07/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			300 J H	I WALKER DRIVE		
	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		indicated she was aware					
	the accounts had	not been closed within					
	30 days.						
	3.1-6(h)						
F0161	Based on record	review and interview, the	F01	61	F-161 I. The new Surety Bond		04/06/2011
		have a Surety Bond in a	101	0.1	has been put into place and no	ow	0.70072011
SS=B	_	t to protect the funds in			covers the cumulative balance	in	
		st Account. The deficient			the Resident Trust Account. II.		
		potential to affect 54 of			There were no other resident accounts that were larger than		
		•			the Surety Bond. III. The syste		
		facility managed funds			change includes a new month		
	for.				report with the Resident Trust		
					Account. This report will be		
	Findings Include	:			completed and provided to the Administrator on a monthly ba		
	1 An undated n	policy titled "Resident			The Business Office Manager		
		as provided by the			be provided education on this		
	_	-			process and providing this rep to the Administrator. IV. The	ort	
		3/7/11 at 10 a.m., and			Business Office Manager and		
		nt. The policy indicated:			Administrator will be responsible	ole	
	_	Funds maintained by the			to audit the Resident Trust		
	facility are protect	2 2			Account, 5 accounts per week	for	
		idence of this security is			30 days, then 5 accounts per		
	available for insp	pection by authorized			month for 150 days, then 3 accounts per month for 180 days	ave	
	representatives of	f state and federal			to total 12 months of auditing.		
	agencies"				Results of monthly reports wil		
					reported to the QA committee		
	2. During review	v of the facility's Surety			monthly for 12 months, to assi		
	_	at 8:10 a.m., the bond			with additional recommendation	ns	
	amount was for \$	*			if necessary. COMPLETION DATE: April 6, 2011.		
		<i>y</i>			DATE. ΑΡΙΙΙ 0, 2011.		
	The Resident Tru	ist Account daily					
		iewed on 3/7/11 at 8:10					
	outanees was tev	10 w ed 011 3/ // 11 at 0.10					

000248

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155357	B. WIN			03/07/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	ļ	
				1	WALKER DRIVE		
		& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	DATE
		owing dates the Trust					
		was greater than the					
	Surety Bond amo	_					
	,						
	12/7/10: balance	e \$34,032					
	12/13/10: balanc	*					
	12/15/10: balanc						
	12/17/10: balanc						
	12/23/10: balanc						
	12/29/10: balanc	-					
	1/5/11: balance 9						
	1/13/11: balance 1/14/11: balance	*					
	2/6/11: balance S						
	2/0/11: balance 3						
	2/13/11: balance 2/28/11: balance						
	2/20/11. outailee	, 457, 100. 10					
	On 3/7/11 at 9:10	a.m., during interview,					
		ice Manager indicated					
	she indicated she	had not been trained on					
	the resident trust	account but there was a					
	corporate consult	tant who was working on					
	the fund account.						
	0 2/7/11	1					
		a.m., during interview, indicated she was aware					
		was not a sufficient t the Resident Trust					
	Account.	t the restuent 11ust					
	Account.						
	3.1-6(i)						
	· - (-)						
			İ	İ			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155357	B. WIN			03/07/20	011
			F		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				I WALKER DRIVE		
	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDL	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·		DATE
F0223		review and interview, the	F02	23	F-223 I. Resident had no recal the incident at the time. II.	I OT	04/06/2011
SS=A	,	prevent verbal abuse			Employee was terminated		
	_	or 1 of 1 reportable			immediatly.Residents were		
	allegation of abu	se in a supplemental			interviewed with no additional		
	sample of 19. (R	Resident # 104)			findings.lll. Systemic change is		
					that all new hires, as well as, a	all	
	Finding Include:				staff competencies will be educated on abuse and report	ina	
					abuse, IV. The Human Resour	~ 1	
	1. A 8/09 policy	titled "Abuse			Director or designee will moni		
	Prevention" was				and give a monthly report on a		
		3/1/11 at 12 p.m., and			new hire files and annual staff		
		t. The policy indicated:			competencies for staff abuse prevention training, 5 times pe		
		of CarDon & Associates			week for 30 days, then 5 times		
	to provide each r				month for 150 days, then 3 tim		
	-	t is free form verbal,			per month for 180 days for 12		
		and mental abuse,			months of monitoring. Results		
		nent, and involuntary			monitoring will be reported to t QA committee, per month, for		
		ive established policies			months, with additional	12	
		hat will provide facility			recommendations as necessa	ry.	
	-	•					
	-	ne knowledge and					
		er ensure each resident is					
		vidual respect and					
		abuse is defined as any					
	· ·	en or gestured language					
	_	ludes disparaging and					
		to residents or their					
	·	in their hearing distance,					
		ents, regardless of their					
	age, ability to con	mprehend, or					
	disability"						
	2. A "Facility In-	cident Reporting Form"					
	dated 6/5/10 was	reviewed on 3/2/11 at 9					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			l ,	ILDING	NSTRUCTION	(X3) DATE (COMPL 03/07/2	ETED
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC		STREET A	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was overheard te better shut your is tongue out." The immediately and pending the investigation the "we joke like the employee was resident did not resident did not remployed by the	indicated a housekeeper Illing Resident # 104 "you mouth or I will rip your event was reported the employee suspended stigation. During the employee indicated that all the time" as terminated and the ecall the event. To on 3/7/11 at 1 p.m., the dicated she was not facility at the time of the had no information to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2011		
NAME OF E	PROVIDER OR SUPPLIER		F		ADDRESS, CITY, STATE, ZIP CODE		
					I WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDL 	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
TAG			F03		F-315 I. Resident #13's cathete	or.	04/06/2011
F0315		ations, interviews, and	1 503	13	tubing and Foley catheter bag	J1	04/00/2011
SS=D		he facility failed to			was re-positioned below the le	vel	
		neter (F/C) bags were			of the bladder. Catheter tubing		
	-	the resident's bladder			was cleansed. II. All residents	with	
	_	sfers and F/C care was			Foley catheters have been identified and were monitored	for	
		personal care in a manner			correct positioning and	101	
		y tract infections for 1 of			appropriate cleansing of the		
		ved with Foley catheter			catheter tubing and no issues		
	in a sample of 19).			were identified. III. The system		
	(Resident #13)				change is that all new hire C.N s will receive education on pro		
					positioning of catheters, include		
	Findings include	:			during transfers and cleaning	ŭ	
					catheter tubing during peri car	e.	
	1. The "Catheter	Care, Urinary" policy			Education was completed on		
	was provided by	the Director of Nursing			3/10/11on proper positioning a cleansing of Foley catheter tub		
	on 3/04/11 at 11:	25 a.m. This current			and transfers with foley cathet	-	
	policy indicated t	the following:			Charge nurses received		
		•			education on observing reside		
	"Purpose				care to determine that cathete	rs	
	-	nis procedure is to			are handled in a manner to prevent urinary tract infections		
		of the resident's urinary			IV. The Unit Manager or desig		
	tract.				will audit Foley catheter tubing		
					bag positioning, transfers with		
	General Guidel	ines			Foley catheters Foley catheter	,	
		drainage bag must be			care and cleansing catheter tubing on all shifts, 5 residents		
		d lower than the bladder			per week for 30 days then 5	,	
	_	event the urine in the			residents per month for 150 da	ays	
	-	age bag from flowing			then 3 residents per month for		
	back into the urin				180 days to total 12 months of		
	oack into the till	iary braduci			monitoring. Results of audits was be reported to the QA committed.		
	2 Om 2/01/11 -4	1.25 n m Dagidant			monthly, for 12 months, to ass		
		4:25 p.m., Resident			with additional recommendation		
	_	ransfer was observed. In			if necessary. Please see		
	preparation, CNA	A #12 was observed to			revised attachment #1 regardi	ng <u>:</u>	
			1		1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155357	B. WIN			03/07/2	011
		I	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	Т	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	hold the resident	's urinary drainage bag			Foley Catheter Care Audit. Ple	ase	
	above the resider	nt's bladder level as she			see revised attachment #2	ina	
	checked the amo	ount of urine in the bag.			regarding: Foley Catheter Tuber Positioned Correctly.	<u>ning</u>	
		e would need to empty			COMPLETION DATE: April 6,		
		age bag prior to the			2011. F-315 I. Resident #13's		
	1	, dark yellow urine was			catheter tubing and Foley		
	_ ·	rinary drainage bag and			catheter bag was re-positioned	t	
	Foley Catheter (1				below the level of the bladder.		
	roley Callicter (1	r/C) tubing.			Catheter tubing was cleansed. All residents with Foley cathete		
	0 2/02/11 6	1.10			have been identified and were		
		1:10 p.m. to 1:30 p.m.,			monitored for correct positioning		
		ansfer with the Hoyer lift			and appropriate cleansing of the	•	
	1 *	e were observed. Upon			catheter tubing and no issues		
	entering the roor	n, CNA #21 was			were identified. III. The system		
	observed transfe	rring the resident from his			change is that all new hire C.N		
	bed to his wheel	chair with his Foley			s will receive education on pro positioning of catheters, includ		
	catheter (F/C) ba	ig in his lap. After			during transfers and cleaning	ii ig	
		ident into his bed, the			catheter tubing during peri care	e.	
	I -	emoved from the room.			Education was completed on		
	1 -	returned to the resident's			3/10/11on proper positioning a		
		ed the resident's F/C bag			cleansing of Foley catheter tub		
		bladder. Cloudy, yellow			and transfers with foley catheten Charge nurses received	ers.	
					education on observing reside	nt	
		ved in the F/C tubing.			care to determine that cathete		
	· ·	the resident, CNA #21			are handled in a manner to		
		cleanse Resident #13's			prevent urinary tract infections		
		a sweeping motion from			IV. The Unit Manager or design		
	·	roin, under the testicles,			will audit Foley catheter tubing bag positioning, transfers with	,	
		bdomen, and then, to the			Foley catheters Foley catheter	.	
	other side of the	groin 3 different times.			care and cleansing catheter		
	No catheter tubii	ng cleansing was			tubing, 5 residents per week f	or	
	observed. After	turning the resident,			30 days then 5 residents per		
	rectal care was completed with a small				month for 150 days then 3		
		n bowel movement			residents per month for 180 da to total 12 months of monitorin		
	observed on the	washcloth. CNA #21			Results of audits will be report		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 03/07/2	LETED	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J F	ADDRESS, CITY, STATE, ZIP CODE H WALKER DRIVE LETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
TAG	then completed him before exiting time during an inimidicated the F/C below the bladded. 3. Resident #13' 3/01/11 at 4:10 p diagnoses include to, profound benurinary retention dementia. The siset assessment, defined the resident was impaired. The recatheter. The physician or Ceftin (antibiotic mouth 2 times a urinary tract infection.)	is care and repositioned ag the room. At this same aterview, CNA #21 abag should be kept ar level at all times. Is record was reviewed on a.m. The resident's ed, but were not limited ign prostatic hypertrophy, and Alzheimer's agnificant minimum data ated 2/14/11, indicated moderately cognitively esident had an indwelling der, dated 12/07/10, was a solonomial to the urine culture, andicated the growth of	TAG	to the QA committee monthl 12 months, to assist with additional recommendations necessary. COMPLETION I April 6, 2011.	y, for	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155357	B. WING 03/07		03/07/2	011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	I WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		l	ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0323	Based on observa	ations, interviews, and	F03	23	F-323 I. Residents #27, #29, #		04/06/2011
SS=E	record review, th	e facility failed to ensure			#44, and #16 were reviewed a	nd	
	personal body ala	arms (PBA's) were turned			all alarms were placed appropriately in accordance to		
		l for 5 of 7 residents			care plan. #21 C.N.A. was		
		BA's (Resident #'s 27, 29,			provided education on using the	ne	
		nd to ensure precautions			Hoyer lift. The resident is safe		
	· ·	-			transferred in the lift. II. All other		
		uring the use of a Hoyer			residents with personal body		
		ident observed (Resident			alarms were reviewed during t	he	
		2 Hoyer lift transfers in a			survey and found to be		
	sample of 19.				appropriate and in accordance with the care plans. All other	•	
					residents who use the Hoyer li	ft	
	Findings include	<u>.</u>			were reviewed during survey a		
					found to be transferred		
	1 On 3/01/11 fr	om 5:30 p.m. to 6:25			appropriately. III. The systemic	:	
		er observation, the			change is that all newly hired		
	following was ob				C.N.A.'s and annual		
	ionowing was or	oserved.			competencies with all C.N.A.'s		
					will be educated on alarms and usage of alarms Education wa		
		's personal body alarm			given on 3/10/11 to nursing sta		
		ved in the "off" position.			regarding Alarms and usage o		
	At this same time	e during an interview,			Alarms. C.N.A.'s will do safety		
	CNA #18 indicat	ed the PBA was off as he			checks at the beginning of the		
	turned it on.				shifts. Charge nurse will do		
					safety checks at the beginning	of	
	Resident #27's re	ecord was reviewed on			their shift. Charge nurse will		
		.m. The resident's			document that personal body	, a	
					alarms are in place and workir on their TAR (Treatment	ig	
	_	ed, but were not limited			Administration Record). The		
		lementia, debility, and			systemic change is that all nev	vly	
		o. The annual minimum			hired C.N.A.'s, and annual		
	data set assessme	ent, dated 12/15/10,			competencies with all C.N.A.'s		
	indicated the resi	dent's cognition was			will be educated on use of the		
	moderately impa	ired. The resident			Hoyer lift. Education was given		
		ve assistance of 1 to 2			3/10/11 to nursing staff regard use of the Hoyer lift per facility		
	•	fers and toileting. The			policy. IV. Unit Manager or		
	persons for truits.	ion and tonoung. The			policy. IV. Offic Mariagor of		
			1		I		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		155357	B. WIN			03/07/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			300 J H	I WALKER DRIVE		
		& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		odv.	DATE
	resident had a fa				Designee will audit personal b alarms to assure that they are functioning properly on all	ody	
	The physician or	der, dated 2/24/11, was a			shifts, 5 residents per week for	r 30	
	pressure alert pa	d to bed and wheelchair			days, then 5 residents per moi		
	to alert staff of u	nassisted transfer.			for 150 days, then 3 residents month for 180 days to total 12		
		ssessment," dated			months of monitoring. Unit Manager or Designee will aud	it	
	1	ted a total score of 14			the use of the Hoyer lift to ass	ure	
		e of 10 or above indicated			safe and appropriate transfer procedure on all shifts, 5		
	the resident was	a high risk for falls.			residents per week for 30 days	,	
					then 5 residents per month for		
	The resident had	a fall on 10/06/10 due to			150 days, then 3 residents per		
	attempting to sel	f transfer out of bed.			month for 180 days to total 12		
					months of monitoring. The res		
	b.) Resident #29	9's PBA was observed in			of the audits will be reported to the QA committee monthly for		
	the "off" position	n. At this same time			months to assist with additiona		
	during an intervi	ew, CNA #12 indicated			recommendations if necessary		
	she had forgotter	n to turn the PBA on			Please see revised attachmen		
	when she had go	tten the resident up for			regarding: Alarm Audit Please see revised attachment #4	•	
	this meal as she	turned the alarm on now.			regarding: Hoyer Lift-Proficier	ncv	
	She indicated the	e resident should have her			of nurse aides. Please see		
	alarm on at all ti	mes when up in her chair.			revised attachment #5 regarding		
		-			Hoyer Lift. COMPLETION DATA April 6, 2011.	IE:	
	Resident #29's re	ecord was reviewed on			η Αριίι 0, 20 I I.		
	3/07/11 at 8:55 a	.m. The resident's					
	diagnoses includ	led, but were not limited					
	"	pility, osteoporosis,					
		acular degeneration -					
		mpression fracture in					
	1	fracture with open					
	reduction in 1999, and neuropathy. The						
		um data set assessment,					
		idicated the resident was					
	January 37 02/11, 111	and the resident was					
	I						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
THAD TEAH	or condition	155357	A. BUILDING B. WING	j		03/07/2	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	STF 30	0 J H '	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident required persons for trans	rely impaired. The extensive assist of 1 to 2 fers and toileting. The cent fall with injury.					
	The physician order, dated 2/24/11, was a clip alarm to her wheelchair to alert staff of unassisted transfer. The "Fall Risk Assessment," dated 2/16/11, indicated a total score of 19 with a total score of 10 or above indicated the resident was a high risk for falls.						
	The nurse's notes indicated the resident had a fall on 2/16/11 at 10:30 a.m. The resident was leaning over in the wheelchair and tumbled forward resulting in a head laceration. The resident was sent to the emergency room where demabond was applied to the area, and the resident returned to the facility.						
	(PBA) was also for position with expression to the same time during turned the PBA of	's personal body alarm found in the "off" bosed wires at the boxed alarm. At this g an interview, LPN #1 on and indicated she e present PBA due to the					
	Resident #25's re	ecord was reviewed on					

l	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	300 J H	ADDRESS, CITY, STATE, ZIP CODI I WALKER DRIVE .ETON, IN46064	3		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	diagnoses includ to, dementia, ost falls. The quarter assessment, dater resident's cognitic impaired. The reassistance of 1 to and toileting. The falls. The physician or dated 2/14/11, which bed and wheelch. The "Fall Risk A 2/13/11, indicate total score of 10 resident was a him. The resident had a.m. when she had while sitting on the d.) Resident #44 (PBA) was also be position. At this interview, LPN # should be on as soon. Resident #44's resident #	der, dated 12/27/10 and as a pressure alert pad to air. ssessment," dated da total score of 6 with a or above indicated the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMP	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	STREET. 300 J H	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE LETON, IN46064	I		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
	ı •	ed, but were not limited unsteady gait. The nitted on 2/25/11.					
	The physician or bed and wheelch	der, dated 2/25/11, was air alarm.					
	2/25/11, indicate	ssessment," dated d a total score of 13 with 0 or above indicated the gh risk for falls.					
	the resident was The resident was orientated to nan	s, dated 2/25/11, indicated admitted at 3:00 p.m. indicated as alert and ne only. Bruising was left elbow and left hand in 2 days ago.					
	was observed in front of the telev working herself the chair. Her perso was observed in this same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time different the same time time.	t 9:00 a.m., Resident #16 her chair in the lobby in ision. She was observed towards the bottom of the nal body alarm (PBA) the "off" position. At uring an interview, LPN e PBA was off as she repositioned the resident.					
	3/04/11 at 10:35 diagnoses includ	ecord was reviewed on a.m. The resident's ed, but were not limited ltiple falls, left arm					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	STREET 300 J H	ADDRESS, CITY, STATE, ZIP COD H WALKER DRIVE LETON, IN46064	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	open reduction in fracture in 2009, Alzheimer's typed data set assessme indicated the resseverely impaire extensive care wand toileting. The with no falls since assessment. The physician or pressure alert parto alert staff of use The "Fall Risk A 11/27/10, indicated with a total score the resident was the resident was The resident had 8/21/10, 8/11/10 5/02/10 where the fall. The fall indicated the alart the alarm was for the "Lifting Portable" policy Director of Nurs	e, left hip fracture with internal fixation, pelvic and dementia - e. The quarterly minimum ent, dated 1/25/11, ident's cognition was d. The resident was ith 1 assist for transfer he resident was indicated be admission/prior der, dated 2/24/11, was d to bed and wheelchair massisted transfers. Assessment," dated died a total score of 15 e of 10 or above indicated a high risk for falls. falls on 11/27/10, 5/23/10, and he alarm sounded during on 11/04/10 at 5:25 p.m. rm did not sound due to und under the resident. Machine, Using a was provided by the ing on 3/03/11 at 8:15 at policy indicated the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL		
		155357	B. WIN			03/07/2	011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	WALKER DRIVE		
RAWLIN		& LIVING COMMUNITY, LLC] PENDL	ETON, IN46064		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		TE	COMPLETION DATE	
IAG	REGULATORT OR	LSC IDENTIFFING INFORMATION)		IAG	Distribute: 1		DATE
	"Purpose						
	*	nis procedure is to help					
	The purpose of this procedure is to help lift residents using a manual lifting devices.						
	General Guidel	lines					
	The portable lift	can be used by one					
	nursing assistant if the resident can participate in the lifting procedures. If						
	not, two (2) nursing assistants will be						
	required to perfor	rm the procedure"					
	On 3/02/11 from	1:10 p.m. to 1:30 p.m.,					
	Resident #13's tra	ansfer and personal care					
	was observed. U	pon entering the room,					
	CNA #21 was ob	served to have the					
	_	ed in the Hoyer lift above					
		s lowered to the bed. No					
	-	nnel were present. CNA					
		d the Hoyer lift from the					
		ed to this resident's room.					
		e during an interview,					
		e did complete the					
	_	lift transfer by herself					
		e did at times if she was					
		lp. She also indicated s not to transfer the					
	resident by herse	11.					
	On 3/03/11 at 8:0)5 a m. during an					
		ON indicated Resident					
	#13's Hoyer lift t						
	"15 5 Hoyel Hit t	iunorei oneuru oe					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIEF	& LIVING COMMUNITY, LLC	STREET A 300 J H	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE ETON, IN46064	;	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	_	2 people present, and if mber was automatically				
	3/01/11 at 4:10 p diagnoses includ to, syncope, debi dementia. The s set assessment, of the resident was impaired. The re assistance of 2 p resident had no fr assessment. The "Fall Risk A 12/20/10, indicate with a total score	ecord was reviewed on o.m. The resident's ed, but were not limited fility, and Alzheimer's ignificant minimum data lated 2/14/11, indicated moderately cognitively esident required total ersons for transfers. The falls since admission/last essessment," dated ted a total score of 14 et of 10 or above indicated a high risk for falls.				

l l		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155357	B. WIN			03/07/2	011
NAME OF B	NOVADED OD GUDDI IED		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			300 J ⊦	I WALKER DRIVE		
	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDL	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02	TAG	·		DATE
F0328		review, observation and	F03	28	F-328 I. Resident # 80 was assessed and oxygen placed	at	04/06/2011
SS=D	, , , , , , , , , , , , , , , , , , ,	cility failed to ensure			1L per order. II. All residents w		
		inistered at the ordered			oxygen were reviewed and for		
		f 1 residents observed			to have oxygen administered p		
	for oxygen admi	nistration (Resident # 80)			order. III. The systemic change		
	in a supplementa	l sample of 19.			communicating all oxygen ord	ers	
					on the TAR (Treatment Administration Record) for qui	ck	
	Findings include	<u>.</u>			reference. Nursing personnel		
					educated on 3-10-11 on noting		
	1. The record fo	r Resident # 80 was			the ordered oxygen rate on the		
	reviewed on 3/4/11 at 10 a.m.				TAR each shift and monitoring	for	
					correct settings. IV. The Unit Manager, Director of		
	Physician orders	for March 2011			Nursing/designee will monitor		
	-	er for oxygen at 1 liter to			oxygen settings in accordance	;	
		continuously by nasal			with the physician's orders on		
	canula.	continuously by hasai			shifts, 5 residents per week or		
	canuia.				oxygen settings for 30 days, the	nen	
	0 2/1/11 -4.5.2/	5 4b			5 residents per month for 150 days, then 3 residents per mo	nth	
		5 p.m., the resident was in			for 180 days to total 12 month		
	_	in her wheelchair. Her			monitoring Results of the au		
	portable oxygen	tank was set at 2 liters.			will be reported to the QA		
					committee monthly for 12	_1	
		p.m., the resident was in			months, to assist with addition recommendations if necessary		
	bed. Her oxyger	a concentrator was set at 3			Please see revised attachmen		
	liters and she wa	s wearing the nasal			regarding: Oxygen Audit.		
	canula. At that t	ime, during interview,			COMPLETION DATE: April 6,		
	LPN # 26 indicat	ted the resident's oxygen			2011		
	should be set at 1	l liter.					
	3.1-47(a)(6)						
	(")(")						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155357	B. WIN			03/07/2	011
NAME OF P	PROVIDER OR SUPPLIER	 L			ADDRESS, CITY, STATE, ZIP CODE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			WALKER DRIVE ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0329		ations, interviews, and	F03	29	<u>F-329</u>		04/06/2011
SS=D	record reviews, the facility failed to				I.		
	ensure non-phari	naceutical interventions			"		
	were attempted f	for behaviors prior to the			Resident #36 was assessed a	nd	
	administration of	f a prn (as needed)			use of non pharmaceutical		
	medication for 1	of 2 residents reviewed			approaches in place per reside care plan.	ent	
	with prn medicat	tions for behaviors			care plan. Resident # 80 was assessed a	and	
	(Resident #36) as	nd to ensure monitoring			blood pressure obtained per th		
	of blood pressures were completed as ordered by the physician prior to the administration of blood pressure medicine for 1 of 2 residents reviewed for blood pressure monitoring (Resident #80) in a				physicians order.		
					II.		
					Residents who are receiving a		
					psychotropic medication were		
	sample of 19.				reviewed by the pharmacist fo		
	-				appropriate medical symptoms		
	Findings include	:			and or diagnosis to warrant the use of a psychotropic medicati		
	C				Any recommendation from the		
	1. The "Behavio	or Assessment and			pharmacist will be addressed	as	
	Monitoring" poli	cy was provided by the			appropriate by physician or		
		ing (DON) on 3/04/11 at			nursing staff, including action to non pharmaceutical intervention		
		current policy indicated			Residents who receive blood	JIIS.	
	the following:	· F			pressure medications that requ	uire	
	"Policy Statemer	nt			monitoring prior to medication		
	- one, outerior				administration have been		
	 1 Problematic b	behavior will be identified			reviewed and blood pressures obtained as needed.		
	and managed app				obtained de fiecaea.		
	and managed app	oroprimery.					
	Policy Interpre	tation and					
	Implementation	unon unu			III.		
	Implementation				The systemic change is review	v of	
	Management				all PRN orders for psychotropi		
	ivianagement				medications in daily clinical		
	1 The stoff will	identify and discuss with			meeting to determine that non		
	1. THE STAIL WILL	identify and discuss with			drug interventions are planned	1	

000248

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		155357	B. WING		03/07/2011	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
				H WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC	PEND	LETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	the practitioner s			and that nurses will provide n drug implementation prior to t		
	nonpharmacolog	ic approaches are	administration of PRN		ile	
	indicated, and will institute such measures			psychotropic medications by		
	to the extent poss	sible.		noting in the nurses' notes the	;	
				non drug intervention.		
	Monitoring			Licensed nurses were provide		
				education on appropriate med symptoms and or diagnosis to		
	2. The staff wi	Ill document (either in		warrant the use of a psychotr		
		ehavior assessment		medication, behavior monitori	· ·	
forms, or other comparable approaches)				documentation and non		
the following information about specific				pharmaceutical interventions		
	problem behaviors:			before administering PRN		
	problem behavio	15.		psychotropic medications.		
	c. Intervention	us attampted		The systemic change is that	all	
	d. Outcomes ass	-		new admission's orders and a	I	
				new orders are going to be		
	interventions"	•		reviewed in daily clinical mee		
				and weekly in At Risk meeting orders that require monitoring		
		11:15 a.m., Resident #36		blood pressure with	,	
		his chair in the lobby		parameters.		
		's station. At this same		Nurses were educated on 3/1	0/11	
	time, the resident	t began yelling for family		on blood pressure including		
	members. Unit I	Manager (UM) #1 was		documentation of monitoring		
	observed to go ta	alk to the resident and		blood pressure prior to administering medications that	at	
	take him from the	e lobby to the dining		have parameters ordered.	"	
	room. In the din	ing room, UM #1				
	obtained some dr	rinks for the resident with		IV.		
	no further yelling	g heard.		The DON/Design	24	
	, ,	-		The DON/Designee will review hour reports and physician or		
	On 3/01/11 at 2:2	25 p.m., Resident #36		for any PRN psychotropic	4013	
		his chair in front of the		medication administration 5 ti	mes	
		lobby next to the nurse's		per week for 30 days, then 5		
		as heard talking out loud		times per month for 150 days	•	
		· ·		then 3 times per week for 180	1	
	at times, LPN #1	1 indicated the resident		days, to total 12 months of		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/07/2011	
 		A. BUILDING B. WING STREET 300 J	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY) monitoring. The DON/Designee will also review MARs for documentation of blood pressures when parameters to dispense are ordered by a physician, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month or 180 days for a total of 12 months of	O3/07/2011 (X5) COMPLETION DATE On es	
	conference during information was a Director of Nursi #36's non-pharma interventions in 1 On 3/07/11 at 8:2 interview, the DC further information non-pharmaceutic Resident #36's be administration of On 3/07/11 at 1:2 interview, UM #1 #36 generally one needed, and he coneeds to you, for bathroom. She a would get confus wife, which could and/or drinks.	g an interview, further requested from the ng concerning Resident acceutical/pharmaceutical 2/10 and 1/11. 25 a.m. during an DN indicated she had no on concerning the use of cal interventions for chaviors prior to the Xanax.		monitoring. Results of the audits will be reported to the QA Committee monthly for 12 months, to assi with additional recommendation if necessary. Please see attachment #7 regarding: 24Hour New/Re-Admission Checklist. Please see attachment #8 regarding: Psychotropic Med Administration & BP Parameter Monitoring Audit COMPLETION DATE: April 6, 2011.	ist ons

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155357	B. WING		03/07/	2011
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J I	ADDRESS, CITY, STATE, ZIP COD H WALKER DRIVE LETON, IN46064	E	
	S HOUSE HEALTH SUMMARY S (EACH DEFICIEN REGULATORY OR 3/02/11 at 12:50 diagnoses includ to, depression an The admission massessment, dated resident's Brief It (BIMS) total scotthe resident's cogimpaired. The physician's cogimpaired.	& LIVING COMMUNITY, LLC TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) p.m. The resident's ed, but were not limited d Alzheimer's disease. Aninimum data set d 12/14/10, indicated the interview of Mental Status re was 6, which indicated gnition was severely order, dated 12/13/10, ing (milligrams) by mouth ded for increased anxiety e in 14 days. order, dated 12/27/10, ing by mouth every day as ty. order, dated 1/07/11, was a mouth 2 times a day as ty. sindicated on 12/13/10 at sident was up in his and was confused. He inot know why he was the was to pick him up. medicated with Xanax used anxiety. A phone the to his daughter, so the	300 J I	H WALKER DRIVE	TION LD BE	(X5) COMPLETION DATE
	down." On this s	ak with her and "calm same day at 8:30 p.m., the cated as calm at this information was				

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIEF	& LIVING COMMUNITY, LLC	STREET.	ADDRESS, CITY, STATE, ZIP CODI H WALKER DRIVE LETON, IN46064	3		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR indicated concert The "Point of Cate computer information indicated at 9:42 behaviors significated at 9:42	are History (CNA's ation)," dated 12/13/10, p.m. the resident's cantly interfered with the	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	No specific infor behaviors was in	nd/or living environment. rmation concerning the dicated.					
	indicated Xanax due to anxiety. confused. No ir concerning any r interventions atte	s, dated 12/16/10, was given at 6:00 p.m. The resident was noted as aformation was indicated non-pharmaceutical empted prior to the f the medication, Xanax.					
		are History," dated ted no behaviors had					
	indicated the res and was alert wir this evening. He p.m. due to the p for increase agita wanted to go hor when his wife ar	s, dated 12/18/10, ident was resting in bed th periods of confusion was given Xanax at 8:00 hysician's order to give ation. The resident me and wanted to know ad daughter would be here. No information was ning any					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	300 J H	ADDRESS, CITY, STATE, ZIP COD H WALKER DRIVE LETON, IN46064	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	non-pharmaceuti attempted prior t the medication, 2	o the administration of					
		re History," dated red no behaviors had					
	indicated at 9:20 given Xanax at 4 The resident was information was non-pharmaceuti	o the administration of					
		re History," dated red no behaviors had					
	indicated Xanax information was non-pharmaceuti	the reason for the					
		re History," dated red no behaviors had					
	The nurse's notes	s, dated 12/29/10, at 9:40					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/07/2011		
		155357	B. WING			03/07/2	U11
NAME OF F	PROVIDER OR SUPPLIER		I		DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
		& LIVING COMMUNITY, LLC	PI	ENDLE	ETON, IN46064		(X5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CORRECTION	
TAG	`	LSC IDENTIFYING INFORMATION)	1	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	p.m. indicated th	e resident had been quiet					
	most of the shift	and had some anxiety					
	_	when Xanax was given.					
		was indicated concerning					
		ceutical interventions					
	of the Xanax me	orior to the administration					
	of the Aanax Inc	uicativii.					
	The "Point of Ca	re History," dated					
	12/29/10, indicat	ed no behaviors had					
	occurred.						
	The nurse's notes	s, dated 1/10/11, indicated					
		nax was given at "6:30"					
	-	No information was					
	indicated concern						
	non-pharmaceuti						
	attempted prior to	o the administration of					
	the medication, 2	Kanax.					
	The "Point of Ca	re History," dated					
		d no behaviors had					
	occurred.	w 110 0 w 110 15 11 w w					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155357	B. WIN			03/07/2011	
NAME OF F	PROVIDER OR SUPPLIER	<u>"</u>			ADDRESS, CITY, STATE, ZIP CODE		
5 4 4 4 1 4 1	0.1.01.05.1.541.711				H WALKER DRIVE		
	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			LETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
F0329		r Resident # 80 was	F03		F-329	04/06/2011	
			103	<i>_ _ _ _ _ _ _ _ _ _</i>	1 020	04/00/2011	
SS=D	reviewed on 3/4/11 at 10 a.m.				l.		
	Current diagnose	es included, but were not			Resident #36 was assessed a	nd	
	limited to, hyper	·			use of non pharmaceutical		
	, 31				approaches in place per reside	ent	
	Physician orders	for March indicated an			care plan. Resident # 80 was assessed a	and	
	order for Norvas	c 10 milligram daily and			blood pressure obtained per th		
	to hold the medic	cation if the systolic			physicians order.		
	blood pressure is	less than 110.			 II.		
	The February 2011 Medication				".		
					Residents who are receiving a		
		Record lacked blood			psychotropic medication were		
		prior to administering the			reviewed by the pharmacist fo appropriate medical symptoms		
	•	, 12, 13, 14, 15, 16 and			and or diagnosis to warrant the		
	24, 2011. 109/55				use of a psychotropic medicat		
	On 2/10/11 at 9 a	om the Newyoga was			Any recommendation from the pharmacist will be addressed		
		a.m., the Norvasc was od pressure of 98/64 and			appropriate by physician or		
		5/11 at 8 a.m., due to a			nursing staff, including action		
	blood pressure of	-			non pharmaceutical intervention Residents who receive blood	ons.	
	blood pressure of	•			pressure medications that req	uire	
	During interview	on 3/7/11 at 12:45 p.m.,			monitoring prior to medication		
	_	Jursing indicated the			administration have been reviewed and blood pressures		
		were not completed.			obtained as needed.	'	
	1	1					
	3.1-48(a)(3)						
	3.1-48(b)(1)				lii.		
						_	
					The systemic change is review all PRN orders for psychotropic		
					medications in daily clinical		
					meeting to determine that non		
					drug interventions are planned	i	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155357	B. WING		03/07/2011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J F	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE LETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				and that nurses will provide not drug implementation prior to the administration of PRN psychotropic medications by noting in the nurses' notes the non drug intervention. Licensed nurses were provide education on appropriate med symptoms and or diagnosis to warrant the use of a psychotromedication, behavior monitorind documentation and non pharmaceutical interventions before administering PRN psychotropic medications. The systemic change is that a new admission's orders and an ew orders are going to be reviewed in daily clinical meeting and weekly in At Risk meeting orders that require monitoring blood pressure with parameters. Nurses were educated on 3/10 on blood pressure including documentation of monitoring blood pressure prior to administering medications that have parameters ordered. IV. The DON/Designee will review hour reports and physician order for any PRN psychotropic medication administration 5 timper week for 30 days, then 5 times per month for 150 days, then 3 times per week for 180 days, to total 12 months of	d ical pic ng ll ll lngs , for lt ld ld ld ld ld ld ld ld ld ld ld ld ld	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER		300 J F	ADDRESS, CITY, STATE, ZIP CODE H WALKER DRIVE LETON, IN46064		
	S HOUSE HEALTH SUMMARY S (EACH DEFICIEN		300 J F	I WALKER DRIVE	on DATE on Of Of One One One One One One One One One One	
				COMPLETION DATE: April 6, 2011.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2011		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	LETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0363	Based on o	bservation,	F03	63	F-363 I. Residents #65, #67, # #79 #81 and #82 were assess		04/06/2011
SS=E	interview a	nd record			and menus were reviewed to provide diets in accordance to	the	
	review, the	facility failed to			physician's orders. II. All diabe residents have been reviewed	tic	
	ensure mer	nus were			the registered Dietician. Diets	Бу	
	followed fo	or 6 of 6			have been reviewed and recommendations have been		
	residents w	rith physician's			addressed. III. The systemic change is that the menu syste	m	
	orders for a	no concentrated			was revised to include appropriate diets for diabetics		
	sweets diet	in a			with orders for alteration of sug content Nursing personnel we	-	
	supplement	tal sample of 19			educated on 3-10-11 on provio		
	(Resident #	[‡] 65, #31, #67,			personnel were educated on	ina	
	#79, #81 ar	nd #82). Of the			3-15-11 and 3-22-11 on provid appropriate diets. IV. The Diet	ary	
	facility's 93	3 residents, 25			Service Manager will determin appropriate diets are provided	to	
	of 25 reside	ents with a			residents for all three meals, be auditing 5 residents per week	•	
	physician's	order for a no			30 days, then 5 residents per month for 150 days, then 3		
	concentrate	ed sweets diet,			residents per month for 180 da to total 12 months of monitorin		
	had the pot	ential to be			Results of the audits will be reported to the QA Committee		
	impacted b	y this deficient			monthly for 12 months, to assi	st	
	practice.				with additional recommendation if necessary. Please see		
	Findings in	iclude:			revised attachment #9 regardii <u>Dietary Audit Tool</u> COMPLETI DATE: April 6, 2011.	-	
	1.) Durin	g a 3/4/11,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B9NP11 Facility ID:

000248

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CORRECTION	155357	A. BUII			03/07/2	
NAME OF I	DROWINED OR CLIDRI IED	<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			1	WALKER DRIVE		
(X4) ID		& LIVING COMMUNITY, LLC STATEMENT OF DEFICIENCIES		ID	ETON, IN46064		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	9:15 a.m.,	the					
	Administrator indicated						
	25 of the	facility's 93					
	residents 1	had physician's					
	orders for	a No					
	Concentra	ited					
	Sweets/Restricted						
	Carbohyd	rate or					
	Carbohyd	rate Controlled					
	Diet, which	ch were all the					
	same diet	per facility					
	practice.						
	2.) Durin	g a 3/4/11,					
	11:10 a.m	., interview,					
	the Admir	nistrator					
	indicated dietary staff are						
	train to fo	llow menus					
	and spread	ds sheets					
	(menu poi	rtion size					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155257		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPL	ETED	
		155357	B. WIN			03/07/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	ETON, IN46064		_
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	DATE
	guides) an	d expected to					
	follow me	nus and spread					
	sheets.						
	3.) Review of a current,						
	3/04, facility document						
	titled "Job Specific						
	Orientatio	n-Dietary					
	Cook", wl	nich was					
	provided l	by the					
	Administr	rator on 3/4/11					
	at 11:12 a	.m. indicated					
	the follow	ing.					
	111 0 10110 W	D ·					
	"training	o is					
	•						
	completed						
	Menu Cyc	cles:					
	Therapeut	ic Diets					
	Menu reci						
	served	rr r r ···					
	SCI VCU						

000248

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO	(X3) DATE COMPL			
		155357	B. WIN	LDING NG		03/07/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Follow me	enus, record					
	substitutio	ons"					
	A review	of					
	current.1/2	25/10, facility					
		d spread sheets,					
		re provided by					
	the Food S	-					
	•	r on 3/1/11 at					
		indicated the					
	following	• •					
	Tuesday 3	3/1/11 lunch-					
	no concen	trated sweets					
	and/or res	tricted					
	carbohydr	rate diets were					
	_	receive an					
		d (1/2 bun,					
	_	,					
	bottom bu	ш по юр)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155357	B. WING			03/07/2	011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	•	300 J H	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΤE	(X5) COMPLETION DATE	
	cheeseburger.							
	Tuesday 3	3/1/11 supper-						
	no concen	trated sweets						
	and/or res	tricted						
	carbohydr	rate diets were						
	menued to receive							
	3/4th's of	a Belgian						
	waffle wit	th restricted						
	carbohydr	rate/sugar						
	syrup.							
	Review of	f an undated,						
		,						
	"Open Fac	olicy titled,						
	-							
		es", which was						
	provided l							
		rator on 3/2/11						
l	at 8:50 a.r 	n., indicated						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/07/2011		
		155357	B. WING			03/07/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDLI	ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ.	DATE
	the follow	ing:					
	"Any sandwich is to be						
	served op	en face is to be					
	served wi	th 1 slice bread					
	or 1/2 bur	1"					
	4.) Durin	g a 3/1/11,					
	11:10 a.m	., interview,					
	Cook #25	indicated she					
	thought an	n open faced					
	sandwich	was a					
	sandwich	served with					
	both sides	of the bun					
	open on the	ne plate with					
	toppings (lettuce,					
	tomato, cl	neese, onion)					
	on the top	bun and the					
	hamburge	r on the bottom					
	bun. She	indicated she					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155357	B. WIN	G		03/07/2	011
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC		300 J H	.DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	did not un	derstand that					
	an open faced sandwich						
	contained	only one slice					
	of bread o	or half a bun.					
	5.) Reside	ent #65's					
	record wa	s reviewed					
	3/4/11 at 1	10:30 a.m.					
	Resident ±	#65's current					
		included, but					
	were not l	ŕ					
		nd dementia.					
	diacetes a	ina acimonia.					
	Resident #	#65 had a					
	current,						
	2/9/11,physician's order						
	for a no concentrated sweets diet.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/07/2011			
		155357	B. WING			03/07/2	011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Resident 7	#65 record						
	indicated the resident							
	had a rese	ent history of						
	blood sug	ar results						
	greater that	an 400 on						
	2/19/11 aı	nd 2/26/11.						
	Resident 7	#65 had a,						
	11/18/10,	current care						
	plan prob	lem/need						
	regarding	diabetes and a						
	potential 1	for unstable						
	blood sug	ars. An						
	approach	to this problem						
	was to ser	ve the resident						
	a diet per	physician's						
	order.							
	During a ?	3/1/11, 11:05						
	a.m. to 12	:00 p.m., lunch						

I '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155357	A. BUI B. WIN	LDING VG		03/07/2	011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	meal serv	ice						
	observation	on, Resident						
	#65 was s	erved a						
	cheesebur	ger with both a						
	top and bo	ottom bun (2						
	slices of b	read).						
	Resident #	#65 consumed						
	the sandw	ich.						
	6.) Resident #67's record was reviewed on 3/4/11 at 10:00 a.m.							
	Resident #	#67's current						
	diagnoses	included, but						
	were not l	imited to,						
	diabetes a	nd dementia.						
	Resident #							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE S COMPLE	
	155357				03/07/20)11
PROVIDER OR SUPPLIER		-	1		Į.	
S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1			
			ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
`			TAG		ATE .	DATE
physician'	s order for a no					
concentrated sweets diet.						
Resident #	#67 had a					
current, 12	2/10, care plan					
	_					
•	•					
_						
by the phy	/sician.					
During a 3	3/1/11, 11:05					
a.m. to 12	:00 p.m., lunch					
meal servi	ice					
observation	on, Resident					
#67 was s	erved a					
cheesebur	ger with both a					
•	`					
	<i>'</i>					
1 ACSIGCIIL †	TO / COIISUITICU					
	PROVIDER OR SUPPLIERS SHOUSE HEALTH SUMMARY'S (EACH DEFICIEN REGULATORY OR Physician's concentrate Resident # current, 12 problem/nodiabetes. to this proserve a did by the physician serve a did by the physician serve and serve a did by the physician serve a did by the phys	DENTIFICATION NUMBER: 155357 PROVIDER OR SUPPLIER S HOUSE HEALTH & LIVING COMMUNITY, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) physician's order for a no	PROVIDER OR SUPPLIER SHOUSE HEALTH & LIVING COMMUNITY, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) physician's order for a no concentrated sweets diet. Resident #67 had a current, 12/10, care plan problem/need regarding diabetes. An approach to this problem was to serve a diet as ordered by the physician. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #67 was served a cheeseburger with both a top and bottom bun (2 slices of bread).	DENTIFICATION NUMBER: 155357 A. BUILDING B. WING	DESCRIPTION DESCRIPTION NUMBER: 155357 ABUILDING B. WING B.	DENTIFICATION NUMBER: 155357 A BUILDING R WING DSJOTZE DS

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	FIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
THI DI LINI	or condition	155357	A. BUILDI B. WING	ING		03/07/2		
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	5	300 J H	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	the sandw	rich.						
	7.) Reside	ent #31's						
	record wa	s reviewed						
	3/4/11 at 1	10:15 a.m.						
	Resident # diagnoses were not l diabetes a							
	order for a	/11, physician's						
	Resident #	#31 had a 1/10, care plan						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		100357	B. WING			03/07/2	UII	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	problem/r	need regarding						
	diabetes.	An approach						
	to this pro	blem was to						
	serve a di	et as ordered						
	by the phy	ysician.						
	During a 3	3/1/11, 11:05						
		:00 p.m., lunch						
	meal serv	ice						
	observation	on, Resident						
	#31 was s							
	ground m							
		ger with both a						
	•	ottom bun (2						
	slices of b	#31 consumed						
	the sandw	icn.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a		COMPL	ETED
		155357	A. BUII		-	03/07/2	011
			B. WIN		ADDRESS CITY STATE SIR CODE		
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					I WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDL	ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0363	8. The record for	Resident # 79 was	F03	63	F-363 I. Residents #65, #67, #		04/06/2011
SS=E	reviewed on 3/7/11 at 10:40 a.m.				#79 #81 and #82 were assess and menus were reviewed to	ed	
-					provide diets in accordance to	the	
	The March 2011	physician orders			physician's orders. II. All diabe		
		er for a regular no			residents have been reviewed		
	concentrated swe	•			the registered Dietician. Diets	~,	
	concentrated SWE	Ci dici.			have been reviewed and		
					recommendations have been		
		meal observation on			addressed. III. The systemic		
	3/1/11 at 5:25 p.1	m., the resident was			change is that the menu syste	m	
	served a full size	waffle and ate 100 % of			was revised to include		
	the waffle.				appropriate diets for diabetics		
					with orders for alteration of su	-	
	O The magainst fo	r Resident # 81 was			content Nursing personnel we		
					educated on 3-10-11 on provious appropriate diets. Dietary	airig	
	reviewed on 3/7/	11 at 10 a.m.			personnel were educated on		
					3-15-11 and 3-22-11 on provide	lina	
	The March 2011	physician orders			appropriate diets. IV. The Diet	-	
	indicated an orde	er for a regular no			Service Manager will determin	•	
	concentrated swe	eet diet.			appropriate diets are provided	to	
	501150111111111111111111111111111111111				residents for all three meals, b	•	
	During the guner	moal observation on			auditing 5 residents per week	for	
		meal observation on			30 days, then 5 residents per		
	_	m., the resident was			month for 150 days, then 3		
	served a full size	waffle and was given a			residents per month for 180 da to total 12 months of monitorin		
	regular syrup.				Results of the audits will be	ig	
					reported to the QA Committee		
	10. The record f	For Resident # 82 was			monthly for 12 months, to assi		
	reviewed on 3/7/				with additional recommendation		
	13,10,104 011 3/1/				if necessary. Please see		
	The Morel 2011	mbraision andors			revised attachment #9 regardi	•	
	The March 2011				Dietary Audit Tool COMPLETI	ON	
	indicated an orde	•			DATE: April 6, 2011.		
	carbohydrate cor	ntrolled diet.					
	During the super	meal observation on					
		m., the resident was					
	p.:	.,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

B9NP11 Facility ID:

000248

If continuation sheet Page 42 of 80

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155357	A. BUILDING B. WING		03/07/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE H WALKER DRIVE	
		& LIVING COMMUNITY, LLC	PENDL	ETON, IN46064	_
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	DATE
		waffle and 2 regular 28. A few minutes later,			
		d the resident to cut up			
		that time indicated the			
	resident needed s	sugar free syrup.			
	_	iew with LPN # 26 on			
	_	he indicated he was			
	•	syrup was not served and the staff to watch the			
	tray cards.				
	3.1-20(i)(4)				
	3.1 20(I)(I)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/07/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET	ADDRESS, CITY, STATE, ZIP CODE H WALKER DRIVE	00/01/2	<u> </u>
		& LIVING COMMUNITY, LLC			LETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0365	Based on	observation,	F03	65	F-365 I. Residents #77 and #9 were assessed and provided	1	04/06/2011
SS=D	review the facility failed			appropriate diets in accordance physician's orders. II. The			
				Registered Dietician and Spee Therapist reviewed all the	ech		
	to ensure	residents who			residents on pureed diet with nectar thick consistency, on 3/21/11. Following the review a	all	
	1 0	cian's orders			diets were provided in approprionsistency III. The systemic	riate	
	•	ed diet with			change is that a new recipe fo preparing puree foods to		
		s thinned to a			nectar-Like consistency was p		
		isistency, were			educated on the new recipe of preparing pureed foods with		
		ets in the nectar			nectar like consistency on 3/2/ and 3/3/11 IV. The Dietary	′11	
		for 2 of 2			Service Manager will monitor to puree diets and the new recipe	е	
		reviewed with			are followed for all three meal by auditing 5 residents per we	eek	
	orders for	•			for 30 days, then 5 residents p		
	_	ck foods diet in			residents per month for 180 da to total 12 months of monitorin Results of the audits will be		
	a sample (reported to the QA Committee monthly for 12 months, to assi		
	Findings i	s #77 and #91). nclude:			with additional recommendation if necessary. Please See revised attachment #9 regarding Dietary Audit Tool. COMPLET DATE: April 6, 2011.	ons ng:	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLE		
		155357	B. WIN			03/07/20)11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	1.) A revi	lew of					
	current, 1/25/10, facility						
	menus and	d spread sheets					
	(portion si	ize guides),					
	which we	re provided by					
	the Food S	Services					
	Superviso	r on 3/1/11 at					
	1:00 p.m.,	lacked any					
	indication	of portion					
	sizes or a	category for a					
	" thinned]	pureed diet					
	with food	in a nectar					
	thick cons	sistency."					
	2.) During	g a 3/1/11,					
	11:05 a.m	. to 12:00 p.m.,					
	lunch mea	al service					
	observation	on, Cook #25					
	indicated she was						
	preparing	the "thinned					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155357	B. WIN	G		03/07/2	011
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC		300 J H	ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	pureed die	ets." She place					
	pureed food items in						
	coffee mu	gs. She added					
	broth juice	e or gravy to					
	the coffee	mugs. She					
	stirred the	mixture with a					
	knife and	served the					
	items to the	ne residents					
	#77 and #	91.					
	3.) During a 3/2/11, 9:00 a.m., interview, Cook #25 indicated she had not received any training regarding how to prepare the a pureed diet with food items thinned to nectar constancy. She indicated the first day she got the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155357	A. BUII B. WIN	LDING G		03/07/2	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	-	STREET A	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	order, she	had no idea					
	what to do so she asked						
	a nurse fo	r guidance.					
	Cook #25	indicated the					
	nurse had	told her to thin					
	the pureed	d food items					
	with broth	or juice and					
	stir then s	top adding					
	broth whe	en the item					
	appeared	thin enough to					
	drink. Co	ok #25					
	indicated	she had not					
	had any tr	aining from the					
	speech the	erapy					
	departmen	nt or a dietary					
	supervisor	r regarding					
	how to pro	epare thinned					
	pureed for	ods. Cook #25					
	indicated	there was no					
	recipe or o	directions					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		A. BUI	LDING	NSTRUCTION	(X3) DATE COMPL	ETED	
NAME OF F	DDOWNED OF Grippi tes		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC		1	I WALKER DRIVE ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	regarding	thinned pureed					
	foods in the	ne menus,					
	recipe boo	ok or any other					
	dietary ma	anual.					
		- /- / /					
	4.) Durin	g a 3/2/11,					
	8:05 a.m.,	interview the					
	Director o	of Nursing					
	indicated	the facility did					
	not have d	lirections for					
	the prepar	ration of a					
	pureed for	ods at nectar					
	consistence	cy until the					
	afternoon	of 3/1/11					
	following	inquires by the					
	survey tea	ım. The					
	Director o	of Nursing					
	indicated	a new policy					
	had been o	developed and					
	provided t	the policy at					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		155357	A. BUIL B. WING			03/07/2		
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC		STREET A	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE	
	the time o	f the interview.						
	The new,	undated,						
	facility po	olicy titled						
	"Direction	ns for Preparing						
	Pureed Fo	ood to						
	Nectar-Like							
	Consisten	cy", which was						
	provided 1	by the Director						
	of nursing	s on 3/2/11 at						
	8:05 a.m.,	indicated the						
	following							
	 "For all ho	ot meats and						
	vegetables	s add 1/2 cup						
		k to each item						
	and stir ur	ntil blended.						
		nsistency (the						
		should coat and						
		e spoon similar						
	!							

000248

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/07/2011		
	PROVIDER OR SUPPLIER		B. WING GO/07/25 TI STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	to unset g	elatin).				
	Continue	adding warm				
	milk until	correct				
	consistence	ey is obtained."				
	9:15 a.m., Administr 2 of the fa	had physician's a thinned				
	record wa 3/1/11 at 3	ent #77's s reviewed on 3:00 p.m. #77's current included, but				
	were not l	imited to,				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	C	X3) DATE SURVEY COMPLETED
ANDILAN	or connection	155357	A. BUI			-	03/07/2011
			B. WIN		DDRESS, CITY, STATE, ZIP COI	DE	
NAME OF I	PROVIDER OR SUPPLIER	l .			WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDLE	ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION DATE
	dysphagia	and dementia.					
	 Resident #	#77 had a					
	current, 2/	/24/11,					
	physician'	s order to					
	modify di	et to a "thinner					
	pureed co	nsistency					
	(nectar lik	te) for all meals					
	but contin	ue thin liquids.					
	Present al	l food/liquids					
	in coffee i	mugs."					
	Resident #	#77 had a					
	2/21/11, "	PLAN OF					
	TREATM	ENT" for					
	speech the	erapy which					
	indicated:						
	"seen at	lunch to assess					
	pt's [patien	nts] swallow.					
	would n	ot/could not					
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	 B9NP11	Facility II	D: 000248 If contin	nuation she	Page 51 of 80

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011		
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	300	JΗ	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	chew any	foods that					
	were put i	n mouth. Pt					
	able to su	ck on straw					
	given 50%	6 cueing to					
	suck and	take drink. Pt					
	was seen	later in day					
	with food	from lunch					
	still in mo	outh unable to					
	swallow	."					
	which ind "1.) thin consistence for all me 2.) contin	"Patient Training" erapy form icated: ner puree ey (nectar-like)					

	IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
	155357	B. WING			03/07/2	011	
		STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064					
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
presented	in cups						
(preferably coffee							
mugs)"							
The area of	of the form						
which was	s signed by						
staff who	had receives						
"training on the above							
recommen	ndations" was						
signed by	only one						
employee	, LPN #5.						
a.m. to 12 meal serve observation #77 was served when in mugs at using the	:00 p.m., lunch ice on, Resident erved the thin nich was served nd prepared above						
	provider or supplier s HOUSE HEALTH SUMMARY'S (EACH DEFICIEN REGULATORY OR Presented (preferabl mugs)" The area of which was staff who "training of recommensigned by employee. During a a.m. to 12 meal servation with the servation of the servation with the servation with the servation of the servation with the	provider or supplier S HOUSE HEALTH & LIVING COMMUNITY, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) presented in cups (preferably coffee mugs)" The area of the form which was signed by staff who had receives	PROVIDER OR SUPPLIER S HOUSE HEALTH & LIVING COMMUNITY, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) presented in cups (preferably coffee mugs)" The area of the form which was signed by staff who had receives "training on the above recommendations" was signed by only one employee, LPN #5. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #77 was served the thin pureed which was served in mugs and prepared using the above	provider or supplier s House Health & Living Community, LLC Summary statement of deficiencies (Each deficiency must be perceded by full regulatory or lsc identifying information) presented in cups (preferably coffee mugs)" The area of the form which was signed by staff who had receives "training on the above recommendations" was signed by only one employee, LPN #5. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #77 was served the thin pureed which was served in mugs and prepared using the above	DENTIFICATION NUMBER: 155357 A. BUILDING B. WING OF CORRECTION 155357		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC	300	JΗ	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	Resident #	#77 was					
	assisted a	nd cued by					
	staff to dr	ink the pureed					
	liquid usii	ng					
	a straw. T	The pureed					
	liquids we	ere observed to					
	be in vary	ring forms of					
	thickness.	The					
	appearance	e of the liquids					
	ranges fro	om thin (a					
	thickness	that would drip					
	from a spo	oon leaving no					
	residue be	chind) to honey					
	thick (a th	nickness that					
	would clin	ng to the spoon,					
	drip slowl	ly and leave a					
	noticeable	e coating					
	behind.)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155357	B. WIN			03/07/2	011
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC			ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	reviewed on 3/1/ Current diagnose limited to, dysph A physician order an order from the thinner puree die with thin liquids. On 3/1/11 at 11:0 meal observation 3 teacups of a puring the super 3/1/11 at 5:25 p.1 served a plate of normal puree for spoon and began time, RN # 28 with was served the country then short record. She then was served the wifood.	es included, but were not agia and dementia. er dated 2/24/11 indicated espeech therapist for a et (nectar consistency)			F-365 I. Residents #77 and #9 were assessed and provided appropriate diets in accordance physician's orders. II. The Registered Dietician and Speet Therapist reviewed all the residents on pureed diet with nectar thick consistency, on 3/21/11. Following the reviewed diets were provided in approprious consistency III. The systemic change is that a new recipe for preparing puree foods to nectar-Like consistency was printo place. Dietary personnel weducated on the new recipe of preparing pureed foods with nectar like consistency on 3/2/2 and 3/3/11 IV. The Dietary Service Manager will monitor the puree diets and the new recipe are followed for all three meal by auditing 5 residents per week for 150 days, then 5 residents per week for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring Results of the audits will be reported to the QA Committee monthly for 12 months, to assi with additional recommendation if necessary. Please See revised attachment #9 regarding Dietary Audit Tool. COMPLETING DATE: April 6, 2011.	e to ech all inate r ut vere 111 hat e s, eek er ays en st ons	04/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	I' '	E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J F	ADDRESS, CITY, STATE, ZIP COD H WALKER DRIVE LETON, IN46064	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	the resident was swallowing the r wanted the residence tar consistence intake. She indice Manager had been	trapist # 29, she indicated having difficulty regular puree diet so she ent on a thinner puree by diet to increase her cated the former Dietary en trained on the thinner d not trained the new to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011	
RAWLIN		& LIVING COMMUNITY, LLC	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE H WALKER DRIVE LETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re .	(X5) COMPLETION DATE
F0371 SS=E	Based on interview review the to ensure of the to serve for employees hands in a prevent the spread of decrease prontaminal	observation, and record e facility failed employees opriate utensils	F03			asils 1. #2, 13, een ing. C All on will	DATE 04/06/2011
	had the poimpact 59 who receive prepared a from the re-	of 59 residents			to total 12 months of monitoring to ensure infection control practices are followed. Result the audits will be reported to the QA Committee monthly for 12 months, to assist with addition recommendations if necessary Please see revised attachmen #10 regarding: Hand Washing Paper Towel dispensing Audit. Please see revised attachmen #11 regarding: Hand Washing COMPLETION DATE: April 6, 2011.	s of all all all all all all all all all al	

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Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE S COMPL		
		155357	A. BUII B. WIN			03/07/2	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	WALKER DRIVE ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	3/2/11, factitled "Per of Food H which was the Admir 3/2/11 at 8 indicated to "Use of G Sanitizedb. Sanit will be use bare hand	w of a current, cility policy, sonal Hygiene fandlers", s provided by histrator on 8:50 a.m., the following:					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JETIPLE CO	NSTRUCTION	COMPI		
		155357	A. BUIL B. WING			03/07/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER	.			WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		PENDLE	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	_	educe potential					
		nission of					
	bacterial or viral agents."						
		ashing/Hand Hygiene" policy					
		e DON (Director of Nursing) a.m. This current policy ring:					
	"Policy Statement						
		ers hand hygiene the primary e spread of infections.					
	Policy Interpretation	n and Implementation					
	fifteen (15) seconds	wash their hands for at least using antimicrobial or oap and water under the s:					
	which hand hygiene professional practic	er direct resident contact (for e is indicated by acceptable e); er assisting a resident with					
	,	g a 3/7/11,					
	2:00 p.m.	interview, the					
	Administr	rator indicated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER S HOUSE HEALTH	& LIVING COMMUNITY, LLC		300 J H	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	59 of the	facility's 93					
	residents of	either eat meals					
	in the mai	n dinning room					
	or receive	room trays					
	that were	prepared for					
	distribution	on in the main					
	dinning ro	oom's adjoining					
	kitchen.						
	4.) Durin	g a 3/1/11,					
	11:05 a.m	. to 12:00 p.m.,					
	lunch mea	al service					
	observation	on, Cook #25					
	was obser	ved in the main					
	dining roo	oms adjoining					
	kitchen pr	reparing plates					
	of food fo	r distribution					
	to residen	ts. Cook #25					
	wore glov	res on both					
	hands. W	ith her gloved					
							•

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	155357	A. BUII B. WIN			03/07/2011	
NAME OF F	PROVIDER OR SUPPLIEF	 	P. ((1))	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	\dashv
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		l	I WALKER DRIVE ETON, IN46064		
(X4) ID		STATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	\dashv
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
1110	hands she touched bread			1110		BARE	
bags, menu cards,							
		pps, food carts					
		zippers, covers					
	and sides)), scoop					
	handles as	nd food trays.					
	With the s	same					
	contamina	ated gloves, she					
	picked up	buns, cheese,					
	lettuce, to	matoes and					
	onions an	d placed them					
	on resider	nts plates. She					
	continued	this process					
	throughou	it the meal					
	service pr	rocess. Cook					
	#25 was c	observed to					
	serve 15 r	residents their					
	meal tray	using this same					
	process of	f handling food					
	with her c	contaminated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE : COMPL		
		155357	A. BUI B. WIN	LDING NG		03/07/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		1	ETON, IN46064		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	gloves.						
	5.) During	g a 3/2/11,					
	7:40 a.m.,	breakfast meal					
	observatio	on in the main					
	dining roc	om, Admissions					
	Coordinat	or #30 was					
	observed j	passing meal					
	trays. Ad	missions					
	Coordinat	or #30 went to					
	the sink in	the main					
	dining roc	om in order to					
	wash her l	hands.					
	Admission	ns Coordinator					
	#30 advan	nced the paper					
	towel prio	r to washing					
	her hands.	. In order to					
	prevent th	e towel from					
	hitting the	faucet,					
	Admission	n Coordinator					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		155357	A. BUII B. WIN			03/07/2	011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC		300 J H	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	#30 use he	er unwashed						
	soiled han	nd to guide the						
	paper tow	el behind the						
	faucet. Sl	ne completed						
	her handw	vash and then						
	dried her	hands on the						
	paper towel she had							
	contamina	ated when						
	guiding th	ne paper towel						
	behind the	e faucet. She						
	then went	to the food						
	service are	ea and obtained						
	another re	esident food						
	tray for di	stribution.						
	6.) Durin	g a 3/2/11,						
	7:41 a.m.,	breakfast meal						
	observation	on in the main						
	dining roo	om, CNA #31						
	was obser	ved passing						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011		
NAME OF I	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
		& LIVING COMMUNITY, LLC			WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE.	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	s. CNA #31					
	went to the sink in the						
	main dinii	ng room in					
	order to w	ash her hands.					
	CNA #31	advanced the					
	paper tow	el prior to					
	washing h	er hands. In					
	order to p	revent the					
	towel fron	n contacting					
	the faucet	, CNA #31 use					
	her unwas	shed soiled					
	hand to gu	aide the paper					
	towel behi	ind the faucet.					
	She comp	leted her					
	handwash	and then dried					
	her hands	on the paper					
	towel she	had					
	contamina	ated when					
	guiding th	e paper towel					
	behind the	e faucet. She					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			ILDING	NSTRUCTION	(X3) DATE COMPI 03/07/2	LETED
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	 STREET A	DDRESS, CITY, STATE, ZIP CODE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	then went	to the food				
	service ar	ea and obtained				
	another re	esident food				
	tray for di	stribution.				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC		COMPLETED	
		155357	A. BUII B. WIN			03/07/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF F	PROVIDER OR SUPPLIEF	₹			I WALKER DRIVE		
RAWLIN	S HOUSE HEALTH	& LIVING COMMUNITY, LLC		I	ETON, IN46064		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	\neg
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0371	7. On 3/01/11 fr	rom 11:35 a.m. to 12:00	F03	71	<u>F-371</u> I. Employee number 25	04/06/2011	l
SS=E	p.m. during lunc	h observation, as drinks			was immediately educated on	.,	
00-L	-	ed to the residents, the			handling food with proper uter		
	following was ol	-			and hand washing on 3/1/201	I	
	lonowing was or	oser ved.			Employee numbers #30, #31, #3, #4, #5, #6, #7, #9, #10, , #	I	
	CNIA //2 1				#14, #15, #16, #1, #17 have b		
		served to dispense paper			educated on hand washing. II.		
		aper towel pumping lever			Education to dietary staff was		
	with one hand ar	nd with her other hand she			provided regarding hand wash	ning.	
	guided this same	e paper towel down from			on 3/1/11. III. The systemic		
	the dispenser to	behind the faucet. After			change is that a new automati	I	
	she completed he	er handwashing, she used			towel dispenser was replaced. new hires and on annual	All	
	this same towel t	_			competency will be educated	n l	
		J			hand washing. All new dietary		
	Activity Assistan	nt #3 was also observed to			hires and annual competency		
	-				be educated on hand washing		
		guide the paper towel			and use of gloves. IV. The		
	-	bensed the towel with the			Director of Nursing and or		
	lever with the oti				Designee will audit all staff on	1	
	handwashing, sh	e used this same towel to			hand washing and towel dispensing on all shifts, with, 5		
	dry her hands.				staff members per week for 30		
					days, then 5 staff members pe		
	Next, LPN #4 w	as observed to dispense a			month for 150 days, then 3 sta	I	
		owel, turned the water on			members per month for 180 da	ays	
		aper towel and set it to			to total 12 months of monitoring	ng	
	•	nk, handwashed, and then			to ensure infection control	,	
		aper towel to dry her			practices are followed. Result		
	*	1			the audits will be reported to the QA Committee monthly for 12		
		he water off. She then			months, to assist with addition	al	
	•	ist a resident with his			recommendations if necessary		
		g the blanket due to			Please see revised attachmen	· • • • • • • • • • • • • • • • • • • •	
	-	it. She left the dining			#10 regarding: Hand Washing		
	room with the unbagged blanket.				Paper Towel dispensing Audit.	· I	
					Please see revised attachmen		
	LPN #5 was obs	erved to dispense the			#11 regarding: Hand Washing COMPLETION DATE: April 6,	<u>l·</u>	
		ced it under her arm next			2011.		
	F 2.F 22 23 22, Pres						

l	IT OF DEFICIENCIES OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J F	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE LETON, IN46064	I		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) andwashed, and then	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
	arm to dry her ha						
	After she dispendibehind the fauce amount of paper handwashed gett behind the fauce towel was used t	sed the paper towel t leaving an accumulated towel on the counter, she ing the paper towel t wet. This same paper o dry her hands, and then, d to wipe the excess water the sink.					
	paper towel while her other hand be	erved to dispense the e guiding it down with ehind the faucet. After e dried her hands with towel.					
	towel behind the	rved to dispense the paper faucet. After e used this same towel to					
	No handgel use observations.	was observed during these					
	p.m. during lunc	om 12:13 p.m. to 1:10 h observation as food served, the following					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED			
		155357	B. WING		03/07/	2011		
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 J H WALKER DRIVE PENDLETON, IN46064					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	Speech Therapis handwash adjust times during this water off and distowel with her wher hands with the CNA #9 was obsthe side of her hat towel, and used the dry her hands. CNA #10 was obsthe side of her hat towel, and then, of the dispense the paphand, and then, of the LPN #5 was observations. LPN #5 was observation was dispense the paphand, and then har towel from under the towel from under the dried her har towel from under the dried her har towel from under the drinks and food the following was activity Assistant dispense the paper	t #8 was observed to ing the water 2 different handwash, turned the pensed a piece of paper et hand before she dried he paper towel. erved to handwash, used and to dispense the paper this same paper towel to be served to handwash, er towel with her wet dried her hands. erved to dispense the it off and positioned it after she handwashed, and with this same paper r her arm. was observed during these om 5:30 p.m. to 6:25 dinner observation while trays were being served,						

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357		(X2) MULTIPLE CO A. BUILDING B. WING	UNSTRUCTION	COME	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J F	ADDRESS, CITY, STATE, ZIP COE I WALKER DRIVE ETON, IN46064	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	handwashed, and towel to dry her	l used this same paper hands.				
	paper towel and faucet with her hused this same to Unit Manager #1 handwash, used the paper towel, her hands. QMA (Qualified #16 was observe the paper towel with the paper towe	bserved to dispense the guide it down behind the ands, handwashed, and owel to dry her hands. 5 was observed to her wet hand to dispense which was used to dry Medication Assistant) d to handwash, dispense with her wet hand, and with this same paper ifferent observations.				
	handwash, dispe her wet hand, an same paper towe CNA #17 was ob paper towel guid with her hand, ha same towel to dr On 3/04/11 at 11 interview, the Do dispense the pap	oserved to dispense the ing it behind the faucet andwashed, and used this				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 03/07/2011			
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	300 J H	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE ETON, IN46064	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	paper towel, and with the same pa	then, turn off the water per towel.				
	3.1-21(i)(2)					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155357	B. WING			03/07/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				WALKER DRIVE		
		& LIVING COMMUNITY, LLC		PENDL	ETON, IN46064		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ļ	TAG	DEFICIENCY)		DATE
F0441	Based on observations, interviews, and		F04	41	F-441 I. Residents #36, #28, # #26 and #27 were reviewed ar		04/06/2011
SS=E	· · · · · · · · · · · · · · · · · · ·	e facility failed to ensure			have had no signs or symptom		
		eve use for 1 of 3 nurses			of infection requiring antibiotic		
	observed (LPN #	(22) during dressing			use since survey completion.	All	
	changes and for 3	3 of 4 nursing staff			identified staff were provided		
	observed during	personal care			education immediately to inclu		
	•	NA #'s 12, 21, and 20) and			hand washing procedure, glov	е	
	,	andling for 2 of 4 staff			use, linen handling and appropriate infection control		
		red (CNA #20 and			practice during medication pas	SS.	
	•	b) during linen handling,			II. All appropriate nursing staff		
	-				be offered education regarding		
		handling of medications			hand washing procedure, glov	е	
	_	n pass for 1 of 4 nurses			use, linen handling and		
	· ·	(24) were performed in a			appropriate infection control		
	manner to prever	nt the spread of infection			practice during medication pas		
	and diseases. Th	is had the potential to			III. The systemic change include that all newly hired Nurses will		
	affect 5 of 93 res	idents observed during			receive education for appropria		
	the survey.	· ·			infection control practice during		
	_	28, 13, 26, and 27)			medication pass and dressing		
	(Itesiaciie ii 5 50,	20, 13, 20, and 27)			changes. In addition, all newly	/	
	Eindings include				hired nursing personnel will		
	Findings include	•			receive education on hand		
					washing, glove use and handli linen. All current nurses will be		
		shing/Hand Hygiene"			offered education hand washir		
	policy was provi	ded by the DON			procedure, glove use, linen	19	
	(Director of Nurs	sing) on 3/04/11 at 11:25			handling and appropriate infec	tion	
	a.m. This curren	t policy indicated the			control practice during medica		
	following:				pass. IV. Director of Nursing a	nd	
	· ·				or designee will audit through		
	"Policy Statemen	nt			direct observations on hand		
	roncy statement				washing procedure, glove use linen handling and appropriate		
	This facility cons	ity considers hand hygiens the			infection control practice during		
	This facility considers hand hygiene the				medication pass on all shifts, 5		
	primary means to prevent the spread of				times per week for 30 days, th		
	infections.				5 times per month for 150 days		
					then 3 times per month for 180)	

000248

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<u> </u>		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155357	A. BUI B. WIN	LDING IG		03/07/2	011
		& LIVING COMMUNITY, LLC		STREET A	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE ETON, IN46064		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	Employees mu least fifteen (15) antimicrobial or and water under c. Before and a contact (for whice indicated by accepractice);g. Before and a with meals; h. Before and af with personal carbathing);k. Before and after a resident's intact a pulse or blood resident);n. Before and with toileting (has and water);q. After contact mucous membrate excretions; r. After handling dressings, bedparts. After handling utensils;	st wash their hands for at seconds using non-antimicrobial soap the following conditions: after direct resident the hand hygiene is eptable professional after assisting a resident the assisting a resident the (e.g., oral care, after changing a dressing; or coming in contact with the skin, (e.g., when taking pressure, and lifting a lafter assisting a resident and washing with soap the twith a resident's nes and body fluids or a soiled or used linens, and, catheters and urinals; as soiled equipment or the ving gloves or aprons;			days to total 12 months of monitoring. Results of the aud will be reported to QA monthly 12 months, to assist with additional recommendations a necessary. See revised attachment #10 regarding: Hawashing & Paper Towel Dispensing Audit. See revised attachment #11 regarding: Hawashing. COMPLETION DATA April 6, 2011.	/ for as and i and	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/07/2011	
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC				STREET A	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Е	(X5) COMPLETION DATE
	8. The use of glandwashing/ha	oves does not replace nd hygiene.					
	Procedure						
	Washing Hands						
	and rub them tog all surfaces, for a seconds under a running water, 3. Rinse hands t water 4. Dry hands the towels and then clean, dry paper	choroughly under running broughly with paper turn off faucets with a towel"					
	Using Gloves" p DON (Director of	rotective Equipment - colicy was provided by the of Nursing) on 3/04/11 at current policy indicated					
	2. To protect we contamination;3. To protect ha infectious mater	nds from potentially ial;					
	Miscellaneous5. Wash hands	s after removing gloves.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357					03/07/2011		
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2	
NAME OF I	PROVIDER OR SUPPLIER	1			WALKER DRIVE		
RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC					ETON, IN46064		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Note: Gloves do not replace handwashing.)"						
	The "Making an	Unoccupied Bed" policy					
	I -	the don on 3/07/11 at					
	1 ^ -	current policy indicated					
	the following:	1 7					
	-						
	"Purpose						
		his procedure is to					
	_	ent who is able to get out					
	of bed with a cle	an, comfortable bed.					
	General Guide	lines					
		te the bed linen. Shaking					
		read germs throughout the					
	room"						
	2 0 2/01/11 6	2.25 4. 2.55					
		om 2:35 p.m. to 2:55 36's personal care was					
	1 * ′	e was transferred to the					
		with gloved hands					
		lent and wiped him with					
		s he was continent of a					
	1	ement. After she					
	_	ves, she was observed to					
	begin handwashi	ing. During this					
		n the towel dispenser					
	l '	NA #12 was observed to					
		owel dispenser with her					
	_	tioned the paper towel					
		ng on the paper towel roll					
	before she closed	d it and dried her hands.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED 03/07/2011			
THEFTERN	AN OF CORRECTION IDENTIFICATION NUMBER: 155357 A. BUILDING B. WING							
			B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				300 J H	WALKER DRIVE			
RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC				PENDLE	ETON, IN46064			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
IAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		IAG			DATE	
] 3 On 3/02/11 fr	rom 10:30 a.m. to 10:40						
		28's personal care was						
	1	gloved hands, CNA #20						
		ncontinent care and was						
	bagging the lines	n. She indicated the						
	resident had been	n incontinent of urine.						
	CNA #20 then re	emoved her gloves and						
		less than 10 seconds after						
		oned the resident in her						
		ted the room, CNA #20						
		d to go get help to transfer						
	the resident to he	er wheelchair (w/c).						
	On 3/02/11 from	10:45 a.m. to 11:05 a.m.,						
		loyer lift transfer was						
		#20 and CNA #21 were						
	observed to hool	k the Hoyer lift to the						
	sling and comple	eted the transfer of the						
	resident from he	r bed to her wheelchair.						
	CNA #21 then re	emoved the Hoyer lift						
		nd continued down the						
	•	ves, handwashing, or						
	ı	erved used. After the						
	_	s removed, CNA #20						
	_	gloves and continued to						
		t with her bra and top.						
	_	ng her in her wheelchair,						
	_	clean up her room.						
	_	her gloves, CNA #20 was						
		te open the resident's quilt						
	· •	er bed to position it on						
	ine resident's bed	d and then, to place a side						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
155357		A. BUILDING			03/07/2011		
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/2	J 11
NAME OF F	PROVIDER OR SUPPLIER			1	I WALKER DRIVE		
RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC				1	ETON, IN46064		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	tray onto the resident's wheelchair before						
		erved used as CNA #20					
	left the room.						
	4. On 3/02/11 fro	om 1:10 p.m. to 1:30					
		13's transfer with the					
	Hoyer lift and pe						
		entering the room, CNA					
	_	d to be completing the					
		r from his wheelchair to					
	his bed. After th	e transfer was complete,					
	CNA #21 remove	ed the Hoyer lift from the					
	room. After CN	A #21 returned to the					
	resident's room, s	she lowered the resident's					
	F/C bag down be	low the bladder and					
	proceeded to und	lress the resident. Next,					
	CNA #21 with gl	loved hands was					
	observed to comp	plete the resident's					
	personal care. A	After putting a new brief					
	on, the resident v	vas repositioned and					
	_	s chin before CNA #21					
	I -	ves. Next, CNA #21 was					
		wash for 10 seconds.					
	· · · · · · · · · · · · · · · · · · ·	served to open the towel					
	dispenser with he						
	^	paper towel roll before					
		ry her hands. At this					
	l -	g an interview, CNA #21					
	_	aper towel holders did					
	1	Before CNA #21					
		she applied 2 more					
		esident per his request					
	and repositioned	the call light and bedside					

Facility ID:

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/07/2011	
	PROVIDER OR SUPPLIER	& LIVING COMMUNITY, LLC	STREET A 300 J F	ADDRESS, CITY, STATE, ZIP COD I WALKER DRIVE .ETON, IN46064	Е		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	trash, urinal, and	collected her bagged soiled linen and left the r handwashing or observed.					
	interview, the Dodispense the papt to 20 seconds, drapaper towel, and with the same path 6. On 3/03/11 fra.m., Resident #2 her right ankle was observed to 10 seconds, donout checked the residence of the removed her propositioned her change. After thand treatment aptobserved to hand seconds, remove pocket, cut a piece different times, of both times, applit (CoverRoll) to the removed her gloresident was reported.	211:45 a.m. during an ON indicated one should er towel, handwash for 15 by one's hands with the then, turn off the water per towel. 28's dressing change on ras observed. LPN #22 handwash for less then hed a pair of gloves, dent's present dressing, tective boots, and feet for the dressing e open area was cleansed plied, LPN #22 was lwash for less than 10 d her scissors from her ce of "CoverRoll" 2 lonned a pair of gloves ed each piece of the tape he dressing, and then, wes each time. After the ositioned, LPN #22 was lwash for less than 15					
		xiting the room. At this g an interview, LPN #22					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155357				ILDING	NSTRUCTION	(X3) DATE : COMPL 03/07/2	ETED
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC			р. W.	STREET A	DDRESS, CITY, STATE, ZIP CODE WALKER DRIVE ETON, IN46064	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	seconds. She als handwash before	o indicated one should and after glove use. 9:44 a.m., Dietary Aide					
	shake open a fold	d 2 different times to ded tablecloth to position om table in preparation al.					
	would apply the	y Aide #23 indicated she tablecloths on the dining nanner to be sure they					
	should be laid ou	ON indicated a tablecloth and unfolded on the top not shook out to position					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155357	B. WIN	WING			011
NAME OF PROVIDER OR SUPPLIER RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC		•	300 J F	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE LETON, IN46064			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0441 SS=E	on 3/1/11 at 3 p.r retrieved a dropp of the medication resident # 26's ro medication. She bathroom and sat back of the toilet She picked up the carried to the me it into the drawer. 9. During a med on 3/1/11 at 3:15 retrieved eye dro cart and entered 1. She opened the e cap clean side do table. When she	ication pass observation p.m., LPN # 24, ps out of the medication Resident # 27's room. ye drops and placed the wn onto the bedside finished administering e picked up the cap and	F04	41	F-441 I. Residents #36, #28, # #26 and #27 were reviewed ar have had no signs or symptom of infection requiring antibiotic use since survey completion. identified staff were provided education immediately to inclu hand washing procedure, glov use, linen handling and appropriate infection control practice during medication pas II. All appropriate nursing staff be offered education regarding hand washing procedure, glov use, linen handling and appropriate infection control practice during medication pas III. The systemic change includ that all newly hired Nurses will receive education for appropria infection control practice durin medication pass and dressing changes. In addition, all newly hired nursing personnel will receive education on hand washing, glove use and handli linen. All current nurses will be offered education hand washin procedure, glove use, linen handling and appropriate infect control practice during medica pass. IV. Director of Nursing a or designee will audit through direct observations on hand washing procedure, glove use linen handling and appropriate infection control practice durin medication pass on all shifts, § times per week for 30 days, th 5 times per month for 150 day then 3 times per month for 180	and and ans and ans and ans and ans and ans and ans and ans and ans and and ans and and ans and and ans and ans and ans and and and ans and an	04/06/2011
					Į.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155357	(X2) MULTIPLE CO A. BUILDING B. WING		COMP 03/07/2	(X3) DATE SURVEY COMPLETED 03/07/2011	
		& LIVING COMMUNITY, LLC	300 J H	ADDRESS, CITY, STATE, ZIP CODE I WALKER DRIVE LETON, IN46064	5		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE COPRIATE	(X5) COMPLETION DATE	
				days to total 12 months of monitoring. Results of the will be reported to QA monomorphisms of the will be reported to QA monomorphisms. See revised attachment #10 regarding washing & Paper Towel Dispensing Audit. See revised attachment #11 regarding Washing. COMPLETION April 6, 2011.	audits Inthly for Inthly for Ins as In Hand In Hand In Hand In Hand		